

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153521		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOME DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 000	<p>INITIAL COMMENTS</p> <p>This visit was a End Stage Renal Disease Facility federal recertification survey</p> <p>Survey Dates: February 20-21, 2012</p> <p>Facility Number: 011854</p> <p>Provider Number: 153521</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Facility Census In-center Hemodialysis: 0 Home Hemodialysis: 62 Peritoneal Dialysis: 49 Total: 111</p> <p>Indiana University Health Home Dialysis was found to be in compliance with the Conditions for Coverage for End Stage Renal Disease Facilities 42 CFR Part 494.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 22, 2012</p>			V 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.